# CHAPTER 16-000 PHARMACY SERVICES

16-001 Standards for Participation: A provider of pharmacy services must be a licensed pharmacy or a dispensing physician. To participate in the Nebraska Medical Assistance Program (NMAP), the provider shall fully meet the standards established by the Department of Health and Human Services Finance and Support and any applicable state and federal laws or regulations governing the provision of the service. Providers shall meet all the Department's pharmacy regulations contained in this chapter.

The pharmacy provider shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit it to the Department to be approved for provider enrollment. Approval may be denied or withdrawn at the discretion of the Director.

16-001.01 Drug Utilization Review: As a condition of participation, the provider is required to -

1. Provide prospective drug utilization review before dispensing each prescription. This shall include screening for -
   a. Therapeutic duplication;
   b. Drug disease contraindications;
   c. Drug interactions;
   d. Incorrect dosage or duration;
   e. Drug allergies; and
   f. Clinical abuse/misuse;
2. Provide patient counseling on all matters which, in the provider's professional judgment, are deemed significant, including -
   a. Name/description of the medication;
   b. Route, dosage form, duration of therapy;
   c. Directions for use;
   d. Adverse reactions, contraindications;
   e. Storage; and
   f. Refill information; and
3. Make a reasonable effort to obtain, record, and maintain adequate patient profiles which, in the provider's professional judgment, are deemed significant. This may include -
   a. Name, address, phone number, age, and gender;
   b. Individual history (i.e., diseases, allergies, drug reactions)
   c. Comprehensive listing of medications; and
   d. Relevant comments.

16-002 Covered Services: NMAP covers outpatient drugs in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Public Law 101-508) including -

1. Legend drugs;
2. Compounded prescriptions; and
3. Over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Purchase (NE-POP) System or LISTED on the Department's Drug Name/License Number Listing microfiche or on the Department's website.

See 471 NAC 16-003, Non-Covered Services; 471 NAC 16-004.01A, Products Requiring Prior Approval; coverage as indicated on NE-POP System; and the Department's Drug Name/License Number Listing microfiche for exceptions to the above.

16-002.01 Compounded Prescriptions: A compounded prescription is a mixture of ingredients which the provider prepares in the pharmacy.

Any mixture of drugs which results in a commercially available OTC preparation is not considered a compounded prescription, for example, dilute HCL, MOM with cascara, OTC hydrocortisone preparations. (See the NE-POP System user's manual for billing instructions.)

16-002.02 Over-the-Counter (OTC) Drugs: NMAP covers only OTC drugs indicated as covered on the NE-POP System or LISTED on the Department's Drug Name/License Number Listing microfiche or on the Department's website. OTC drugs must be prescribed by a licensed practitioner.

16-002.03 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 6 listed in the definition of "Treatment Services" in 471 NAC 33-001.03. These services must be prior authorized by the Medicaid Division of the Department of Health and Human Services Finance and Support.

16-003 Non-Covered Services: Payment by NMAP will not be approved for:

1. More than a three-month supply of birth control tablets. More than a three-month supply of oral medication. More than 100 tablets or capsules of medication taken once daily. More than a three-month supply of any other medication, except injectable medications. More than a one-month supply of any injectable medication, except insulin and those injectable drugs with a duration of greater than one month from one dose (e.g., Lupron Depot 4 month, Depo-Provera Contraceptive 150 mg.).
2. Experimental drugs or non-FDA approved drugs;
3. Drugs or items when the prescribed use is not for a medically accepted indication;
4. Drugs or items prescribed or recommended for weight control and/or appetite suppression (see 471 NAC 16-004.03);
5. Liquors (any alcoholic beverage);
6. D.E.S.I. drugs and all identical, related, or similar drugs;
7. Personal care items (examples: non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, and contact solutions);
8. Medical supplies and certain drugs for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) patients (see 471 NAC 7-000 and 16-004.04);
9. Over-the-counter (OTC) drugs not listed on the Department's Drug Name/License Number Listing microfiche;
10. Drugs or items used for cosmetic purposes or hair growth;
11. Baby foods or metabolic agents (Lofenalac, etc.,) normally supplied by Nebraska Department of Health and Human Services (see 471 NAC 16-002.03 for exceptions);
12. Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the drug rebate program;
13. Smoking cessation products;
14. Products used to promote fertility;
15. Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;
16. Drugs, items or products of manufacturers/labelers that are identifiable as non-covered on the Ne-POP system, or on the Department's Drug Name/License Number listing, or on the Department's website;
17. Drugs, classes of drugs or therapeutic categories of drugs that are Medicare Part D Drugs and Medicare Part D Covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D Plan (see 471 NAC 3-004 for definitions of Medicare Part D Drugs, Medicare Part D Covered supplies and equipment, Medicare Part D and Medicare Part D plan); and
18. Drugs or classes of drugs approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction, or drugs or classes of drugs that are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs that are approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or erectile dysfunction, and are prescribed for those other conditions may be covered, but NMAP may require prior authorization. (See 471 NAC 16-004).

## 16-004 Limitations and Requirements for Certain Services

16-004.01 Prior Authorization: The Department requires that approval be granted prior to payment for certain drugs or items. Physicians wishing to prescribe these drugs or pharmacists shall obtain prior authorization, by submitting the request by standard electronic transaction or by phone or mail, from -

The Pharmacy Consultant (or designee)
Nebraska Department of Health and Human Services Finance and Support
Medicaid Division
P. O. Box 95026
301 Centennial Mall South, 5th Floor
Lincoln, NE 68509
(402) 471-9379

The Department (and/or its designated contractor) will respond to any request for prior authorization within 24 hours of receipt of the request.

Prior authorization can be verified by submitting a claim via the NE-POP System. If prior authorization is not verified through the NE-POP System, the pharmacist may contact the Department (or its designated contractor) for prior authorization approval. If the pharmacist has not received an authorization from the Department for that drug product, payment may be denied. The Department (and/or its designated contractor) will notify the pharmacy provider if the authorization has been granted, the eligible dates of the authorization, and the physician who requested the authorization. The prior authorization is given for the drug product, the client, the prescribing physician, and prior authorization dates.

The Department or the Department's contracted Drug Use Review Contractor operates a Drug Use Review (DUR) program. The DUR program shall be in compliance with U.S.C., Title 42, Chapter 7, Subchapter XIX, Section 1396r – 8. The DUR program consists of prospective drug review, retrospective drug review, the application of explicit predetermined standards and an educational program. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary and that they are not likely to result in adverse medical results. All DUR Board meetings shall be open to all interested parties who wish to provide comments concerning any issue under review by the DUR Board. The DUR Director shall develop an agenda for each meeting and make it available to all interested parties at least 30 days before the meeting. The DUR contractor may charge a reasonable fee for providing copies and mailing information to interested parties.

The Drug Use Review Board must, upon the Department's request, review drugs or classes of drugs and make recommendations to the Department regarding drugs or classes of drugs for prior authorization. The Department makes the final decision on which drugs or classes of drugs will require prior authorization.

For those drugs that will require prior authorization, the DUR Board must develop and recommend prior authorization criteria to the Department. The Department may accept, reject, or modify the recommended criteria.

The Department may also determine that drugs or classes of drugs will require prior authorization. The Department must require the DUR Board to develop and recommend prior authorization criteria for these drugs. The Department may accept, reject, or modify the recommended criteria. The Department shall notify providers of prior authorization criteria through provider bulletins prior to implementation. Comments or concerns regarding prior authorization criteria may be communicated to the pharmacy consultant. The DUR Board shall review existing prior authorization criteria every 12 months.

The Department may add a drug to the list of drugs that require prior authorization before consulting the DUR board. In this situation, the issue of prior authorizing that drug must be added to the next regularly scheduled DUR board meeting. This may necessitate that the DUR director waive the 30-day notification rule with the concurrence of the drug's manufacturer, or its being placed on the agenda may be delayed until a 30-day notice can be given.

The manufacturer or any interested party may request that a drug on the prior authorization list be placed on the agenda of a DUR board meeting, but no drug will be placed on the DUR agenda more than once every 12 months without the consent of the DUR director, in consultation with the Department's Pharmacy Consultant. The manufacturer of the drug may request that the DUR director waive the 30-day notification rule when asking to have its product placed on the agenda.

The manufacturer, or any interested party, may request DUR Board review of any new drug, or soon to be released drug pending FDA approval. The manufacturer of any new drug, or soon to be released drug pending FDA approval, may request that the DUR director waive the 30-day notification rule for its product.

16-004.01A Products Requiring Prior Approval: The following products require prior approval:

1. Sunscreens (Example: Presun 29, Solbar-50);
2. Certain modified versions, double-strength entities, or products considered by the Department to be equivalent to drug products contained on the state or federal upper limit listings (Example: Libritabs, Keftabs);
3. Human Growth Hormone;
4. Erythropoietin (Example: Epogen, Procrit);
5. Drugs or supplies intended for convenience use (Example: Refresh Ophthalmic 0.3 ml. and Novalin penfil insulin);
6. Drugs used for prevention of infection with respiratory syncytial virus (e.g., respiratory syncytial virus immune globulin, palivizumab); and
7. Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophogeal reflux disease, ulcers or dyspepsia (examples: omeprazole, famotidine);
8. Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation or fever (examples: butorphanol, carisoprodol, tramadol);
9. Certain drugs or classes of drugs used for relief of cough and/or symptoms of the common cold, influenza or allergic conditions (examples: loratadine, zanimivir, oseltamivir);
10. Certain drugs or classes of drugs that are used for non-covered services or indications (see 471 NAC 16-003 Non-Covered Services) and for covered services or indications (examples: orlistat, sildenafil);
11. Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings; and
12. Certain drugs or classes of drugs upon initial availability or marketing.

Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or the Department's Drug Name/License Number Listing microfiche or on the Department’s website.

16-004.02 Milk Substitutes: See 471 NAC 7-000.

16-004.03 Anti-Obesity Agents: NMAP does not cover any drug or item prescribed or recommended for weight control and/or appetite suppression.

16-004.04 Pharmacy Services for Nursing Facility (NF) and Intermediate Care Facility for the Mentally Retarded (ICF/MR) Clients

16-004.04A Non-Covered Items: NMAP does not cover the following items as pharmacy services for clients residing in a NF or ICF/MR:

1. Hydrogen peroxide;
2. Rubbing alcohol; and
3. OTC enemas.

The NF or ICF/MR may be reimbursed for these items under the Department's payment plan for NF and ICF/MR services.

For clients residing in NFs and ICF/MRs, the Department does not cover medical supplies or durable medical equipment as pharmacy services. See 471 NAC 7-000 ff.

16-004.04B Replacement Cost: Providers shall not duplicate medication for nursing facility or ICF/MR clients at the Department's expense. The pharmacy or the facility is responsible for providing a replacement. Examples of situations which are NOT to be billed to the Department: If the client's medication is:

1. Lost;
2. Broken;
3. Misplaced;
4. Not received by the facility;
5. Destroyed:
    a. During a client's temporary absence from the facility (e.g., during therapeutic leave days);
    b. During the 15-day bedhold period - this is the time during which the NF or ICF/MR is paid the usual rate to hold the client's bed even though the client is not in the facility;
    c. Following a change of directions; or
    d. At any time that the medication is ordered for the client, unless the medication has expired.

16-004.04C Dispensing Fees: Pharmacies providing medications to NF and ICF/MR patients are allowed one dispensing fee per recipient and drug per month.

16-004.04D Unit Dose:

16-004.04D1 Definitions:

Traditional bottle method: Dispensing multiple tablets and capsules in one vial or bottle. This excludes systems such as cassettes, individually packaged doses on cards containing multiple doses and all similar systems.

Unit dose is a system of drug packaging, dispensing, returning, billing and crediting by a unit dose provider.

Unit dose packaging is drug packaging approved by the Nebraska Board of Pharmacy.

Unit dose dispensing is the provision to the patient of a 14-day or less supply of a drug in unit dose packaging.

Unit dose returning is the process of returning unit dose packaged drugs to the dispensing pharmacy.

Unit dose billing is billing the Department one time per calendar month for the quantity of drug used by the patient during the month (see 471 NAC 16-004.06E for exceptions). The quantity used is the difference between the quantity dispensed and the quantity returned. (Note: See 471 NAC 16-004.04B, Replacement Cost, for examples of drugs which are NOT considered to have been used by the patient and are NOT billable to the Department). The date of service for each unit dose billing shall be: (a) consistent from month to month, and (b) the date during the month that the last dispensing occurred, or the final day of the calendar month.

Unit dose crediting is a process of issuing credits by the pharmacy to the Department for drugs accepted for return into inventory that were previously billed to and covered by the Department.

Unit dose provider is a pharmacy approved by the Department as a unit dose provider. Initial approval is contingent upon written agreement by the provider and demonstration by the provider, to the satisfaction of the Department, of the provider's ability to use unit dose packaging, unit dose dispensing, unit dose returning, unit dose billing and unit dose crediting. Continuing approval is contingent upon the provider's actual performance as specified in the written agreement.

16-004.04D2 Reimbursement: The Department shall reimburse only Unit Dose Providers for prescribed drugs dispensed to Medicaid clients residing in Nursing Facilities or ICF/MRs. A nursing facility may submit a written request to the Department to waive the unit dose packaging requirements for clients participating in a rehabilitation program that includes training in medication management under the traditional bottle method. If a waiver is granted, the Department will notify the facility and the pharmacy of approval of the request.

16-004.04D2a Exception: Pharmacy providers that dispensed prescribed drugs to all Medicaid clients residing in a Nursing Facility or ICF/MR via a traditional bottle method as of August 28, 1999, shall be allowed to continue to provide services to those clients in that Nursing Facility or ICF/MR. This exception shall be granted for one year following the effective date of this regulation.

16-004.04E Drugs Returned for Credit: Providers that accept returns of dispensed drugs from long term care facilities shall credit the Department for those drugs. A drug cost level, below which credits shall not be mandatory, may be established by the Department.

16-004.05 Medical Supplies and Durable Medical Equipment: Any medical supply or durable medical equipment indicated as covered on the NE-POP System or listed on the Department's Drug Name/License Number Listing microfiche or on the Department's web site is covered as a pharmacy service under this chapter.

16-004.06 Quantity Limitations: The Department imposes the following quantity limitations on certain drugs.

16-004.06A Minimum Quantity for Package Size: Federal regulation requires certain medications to be dispensed in their original unopened containers. NMAP does not cover these drugs unless they are dispensed in an original unopened container (Example~~s~~: Nitroglycerin sublingual). The Department notifies all pharmacies of these products via the Department's Drug Name/License Number Listing microfiche or on the Department's web site. This information is also available through the NE-POP system.

16-004.06B Maximum Quantities: See 16-003 Non-Covered Services.

16-004.06C Injections: The Department applies the following limitations to injectable drug products:

1. Only those injections that are either self administered by the client or are administered for the client at the client's place of residence are reimbursable. Injections that are administered by the physician or hospital are not reimbursable through the outpatient drug program (see 471 NAC 10-003.02 ff. and 18-004.05 ff., and 18-004.28 ff.);
2. Whenever available and the necessity warrants, multi-dose vials of medication must be dispensed rather than single-dose vials or unit-dose syringes;
3. The Department allows one dispensing fee for each vial of influenza or other vaccines intended for mass injections of clients. The provider shall submit a single drug claim for these vaccines. The drug claim must include -
   a. A complete list of the names of all clients who received injections from each vial, either on the back of the claim or as a separate list attached to the claim; and
   b. The case number and ID number of one of the clients who received an injection listed on the drug claim;
4. Single-dose syringes are reimbursed at the proportionate cost of a multi-dose vial plus the same proportion of the dispensing fee;
5. Maintenance injectable medications which are not reconstituted or admixed by the pharmacy prior to administration to the patient must be dispensed and billed for the full month's supply;
6. Non-maintenance injectable medications and those injectable medications which must be reconstituted or admixed by the pharmacy prior to administration to the patient including subcutaneous, intramuscular, hydration and intravenous medication delivery by large volume parenteral, piggyback, syringe pump or other methods may be provided at the pharmacist's discretion. Courses of therapy of ten days or less duration shall be billed at the end of the course of therapy. Courses of therapy of greater than ten days duration shall be billed at the end of the course of therapy or after each ten days of therapy; and
7. Injectable medications administered by implanted or similar devices may be billed by the pharmacy when the device is filled. Note: The Department may require you to bill Medicare before billing Medicaid, when appropriate.
8. Total parenteral nutrition (TPN) must be billed through the supplier program. This includes the amino acids, carbohydrates, lipids and all additives. All TPN-compatible additives must be billed through the supplier program regardless of who completes the addition of the ingredient or the method of administration.

16-004.06D Maintenance Drugs: The Department requires that any other maintenance drug or any drug used in a chronic manner be prescribed and dispensed in a minimum of a one-month supply.

Note: Providers shall not reduce prescriptions which are written for quantities larger than a month's supply to a month's supply. The Department considers prescription splitting to be fraudulent.

16-004.06E Exceptions to Quantity Limitations: The Department allows the following exceptions to the quantity limitations of this subsection only for those clients that are receiving their medications by/through a non-unit-dose system, except where noted otherwise:

1. When the prescribing physician first introduces a maintenance drug to a patient's course of therapy, the physician may prescribe as his judgment dictates. Pharmacists shall indicate that this is the initial filling of the medication when filing the drug claim. Any subsequent dispensing of this maintenance drug must be prescribed and dispensed in at least a month's supply.
2. When the prescribing physician's professional judgment indicates that these quantities of medication are not in the patient's best medical interest, the physician may prescribe as his/her judgment directs. This includes limitations for lock-in clients. The pharmacist shall maintain documentation that an exception is being made to the Department's requirements.

3. The Department will consider replacement of any lost, misplaced, or stolen drug products for clients, only when the pharmacy provider documents the conditions that require replacement. The Department will require additional information (police reports, etc.) prior to replacing controlled substances.
4. Schedule II drugs are exceptions to the quantity limitations. This also applies to unit dose systems, unless the Schedule II drug is used in a chronic or maintenance manner (e.g., methylphenidate for certain chronic conditions).
5. The Department will accept certain original shelf package sizes of medication, under the following conditions:
   a. An original shelf package of 480 ml, or less when not packaged in the pint size, is sufficient for the quantity limitations requirement for liquids. This also applies to unit dose systems;
   b. An original shelf package of l00 tablets or capsules, or less when not available in the 100 tablet or capsule size, for seldom-prescribed solid dosage drugs is sufficient for the quantity limitations requirement;
   c. Original shelf packages of l00 tablets or capsules of routinely prescribed drugs are not acceptable as sufficient for fulfillment of the quantity limitations requirement. The full month's supply must be prescribed and dispensed; and
   d. Ready-made ointments, creams, etc., when used in a chronic or maintenance manner, may be dispensed in an original shelf package size provided the original size is closest to the needed amount of medication. This also applies to unit dose systems.

16-004.07 Utilization: Since it is the pharmacist's professional responsibility to ascertain that drugs are being utilized according to the prescriber's directions and that no abuse or overuse exists, the Department will not reimburse pharmacists for prescriptions which demonstrate a lack of this professional obligation. The Department recommends that providers maintain patient record systems or other adequate records to prevent these errors in dispensing.

The Department's professional staff is responsible for determining whether a claim violates the Department's regulations.

The NE-POP system will identify drug claims when potential overuse exists; these claims will be denied.

## 16-005 Payment for Pharmacy Services

### 16-005.01 Dispensing Fees

16-005.01A Pharmacies: The Department assigns a dispensing fee to each individual retail pharmacy and hospital pharmacy. The fee is calculated from the information obtained through the Department's prescription survey. The Department notifies each pharmacy of its dispensing fee.

Note: If a pharmacy accepts a lesser fee from any other third party program, the Department may adjust its assigned dispensing fee to reflect this variance in total charge.

16-005.01B Dispensing Physicians: The Department assigns a dispensing fee to a dispensing physician only when there is no pharmacy within a 25-mile radius of the physician's place of practice.

### 16-005.02 Drug or Ingredient Cost

16-005.02A Federal Upper Limit (FUL): Certain multiple source drug products will have an upper limit of reimbursement assigned by the Federal Government. This limit is equal to 150 percent of the product's lowest price that is published in current national compendia of drug cost information. Additionally, at least three suppliers must list the product which has been classified by the FDA as Category A in its most recent publication of Approved Drug Products with Therapeutic Equivalence Evaluation (Orange Book).

The Department notifies all pharmacies of products which have been designated as FUL products and the respective FUL values via the NE-POP system and the Department's Drug Name/License Number Listing microfiche or on the Department’s website.

16-005.02B State Maximum Allowable Cost (SMAC): Certain multiple source drug products will have a state maximum allowable cost assigned by the Medicaid Division of the Nebraska Department of Health and Human Services Finance and Support. The SMAC limit is the cost at which the drug is widely and consistently available to pharmacy providers in Nebraska. The determination of which products are assigned SMAC limits is the direct responsibility of the Medicaid Division in conjunction with the Nebraska Pharmacists Association Medicaid Advisory Committee. Any individual or organization may request a revision in a SMAC limit directly from the Department.

The Department notifies all pharmacies of products which have been designated as SMAC products and the respective SMAC values via NE-POP system and the Department's Drug Name/License Number Listing microfiche or on the Department’s website.

16-005.02C Estimated Acquisition Cost (EAC): All drug products, including the FUL products and SMAC products, will be assigned as estimated acquisition cost. The EAC is defined as the average wholesale price (AWP) as published by First Data Bank less eleven percent. The Department will be responsible for assigning the EAC limits for all drug products. Any individual or organization may at any time request a revision in any EAC value directly from the Department.

16-005.02D Cost Limitations: See 471 NAC 16-005.04A.

Note: Payment levels for all drugs will not exceed, in the aggregate, upper levels of reimbursement established by federal code or regulation.

16-005.02E Physician Certification of FUL/SMAC Drugs: If the prescribing physician requires that a brand name product of a federal upper limit (FUL) or a state maximum allowable cost (SMAC) designated drug (see 471 NAC 16-005.02A and 16-005.02B) is medically necessary, the Department requires the physician to sign and date Form MC-6, "Physician Certification," (see 471-000-84). The FUL/SMAC limitation does not apply when the prescribing physician certifies on Form MC-6 that a brand name product is medically necessary and the Department shall reimburse the pharmacy provider at the EAC value for the trade name drug product. If Form MC-6 is not completed, the Department shall reimburse the pharmacy at the FUL/SMAC limit for the drug product.

16-005.02E1 Completion of Form MC-6: The Department requires completion of the physician certification form to meet federal requirements. Form MC-6 must:

1. Contain the handwritten signature of the prescribing physician. Rubber stamp signatures, initials, etc., are not acceptable.
2. A separate MC-6 Form is required for each drug product.
3. The original (top) copy of Form MC-6 must be submitted to the Department-designated contractor.
4. The duplicate copies are to be retained by the dispensing pharmacy provider and prescribing physician and serve as their proof of certification. The Department does not provide additional authorization.
5. The original and subsequent drug claims must be checked "dispense as written"; and
6. A new Form MC-6 is required when the effective dates of the certification expire or prescribing physician has changed.

16-005.03 PRICING INSTRUCTIONS: PHARMACISTS SHALL NOT, UNDER ANY CIRCUMSTANCES, SUBMIT CHARGES TO THE DEPARTMENT WHICH EXCEED THE PHARMACY'S USUAL AND CUSTOMARY CHARGE.

16-005.03A Pricing: Any loss leader prices, shelf prices, sale prices, cash only prices, coupon certificates, newspaper or brochure ad prices, that are in effect on the date the prescription is dispensed must be considered the pharmacy's usual and customary charge to the general public.

16-005.03B Price Matching: When a pharmacy lowers its usual and customary price for a prescription (for example: to match a competitor's price), all claims submitted to Medicaid for the same drug and quantity dispensed during that business day must also be billed at the lowered price.

16-005.04 Payment Methodology

16-005.04A Legend Drugs and Compounded Prescriptions: The Department reimburses legend drugs and compounded prescriptions (except birth control products) at the lower of -

1. Product cost (FUL, SMAC, or EAC) plus the assigned dispensing fee(s); or
2. The pharmacy's usual and customary charge to the general public (see 471 NAC 16-005.03).

16-005.04B Unit Dose Prescriptions: The Department defines unit dose at 471 NAC 16-004.04D. Unit dose providers are allowed one dispensing fee per recipient and drug per month. For exceptions to the one dispensing fee per recipient and drug per month see 16-004.06E.

The Department reimburses unit dose prescriptions at the lowest of -

1. Product cost (FUL, SMAC, or EAC) plus assigned dispensing fee(s); or
2. The pharmacy's usual and customary charge to the general public (see 471 NAC 16-005.03).
   Note: The Department does allow the pharmacy provider to maintain a different usual and customary charge for those drug products dispensed through a recognized unit dose distribution system than the same drug products dispensed through a bottle. This applies only to legend drugs dispensed through a unit dose distribution system (capsules, tablets, etc., and not creams, or liquids). This usual and customary variance is not allowable for OTC drug products.

16-005.04C OTC Drugs: The Department reimburses LISTED OTC drugs at the lowest of -

1. Product cost (FUL, SMAC, or EAC) plus the appropriate dispensing fee(s); or
2. The pharmacy's usual and customary shelf price to the general public (maximum of FUL, SMAC, or EAC cost, plus a 50% mark-up).

16-005.04D Birth Control Products: Birth control products are reimbursed at the lowest of -

1. Product cost (FUL, SMAC, or EAC) plus the appropriate dispensing fee(s); or
2. The pharmacy's usual and customary charge to the general public (maximum of FUL, SMAC, or EAC cost, plus a 50% mark-up).

Family planning agencies must bill for birth control products dispensed by a family planning agency and are reimbursed at actual acquisition cost, plus a 50% markup.

Note: The Department will not approve payment for more than a three months' supply of birth control tablets.

16-005.04E Sales Tax: The State of Nebraska is tax exempt; therefore, providers do not charge sales tax on claims to the Department.

16-005.05 Third Party Liability: The pharmacy provider shall bill any third party resource for claims before billing Medicaid. All third party resources available to Medicaid clients must be utilized for all or part of their medical costs before Medicaid. Third party resources are any individual, entity, or program that is, or may be liable to pay all or party of the cost of any medical services furnished to a client. See 471 NAC 3-004 for further policy on third party liability.

## 16-006 Billing Requirements

16-006.01 Drug Claims: Claims for pharmacy services must meet the requirements listed in the NE-POP System user's manual. The same standards apply to non-NE-POP system claims.

16-006.02 Medical Supplies and Durable Medical Equipment Claims: Providers shall bill electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, "Health Insurance Claim Form," (see 471-000-55) to submit claims for medical supplies and durable medical equipment unless otherwise stipulated. See 471 NAC 7-000 on durable medical equipment and medical supplies.

16-006.03 EMC Requirements: While the Department utilizes the NE-POP System, providers are responsible for any errors, omissions, or inappropriate billings submitted by themselves or on their behalf by billing agents. The submission of any electronic media claim for reimbursement by the provider or by an approved company or organization on behalf of an approved provider constitutes certification that -

1. The services or items for which payment is claimed were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;
2. The amounts claimed are in accordance with the Department's regulations, and no additional charge (other than Medicaid copayment) has been or will be claimed;
3. Each service is documented and the documentation is open to audit by the Department or its agents; and
4. The charge does not exceed the pharmacy's usual and customary charge to the general public.

16-007 Services to the Ineligible Mother of an Eligible Unborn Child: NMAP covers services for the ineligible mother of an eligible unborn child under the following conditions.

16-007.01 Covered Individuals: The individuals covered under this Medicaid-defined category include those women whose Nebraska Medicaid Card, the Nebraska Medicaid Eligibility System (NMES), or the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) indicates eligibility for the unborn/newborn but not for the mother. A woman with this type of eligibility status is only eligible for the services defined under this section.

16-007.02 Eligibility Limitation: This Medicaid coverage ends on the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

16-007.03 Covered Services: Under this benefit, NMAP covers the following services:

1. Pregnancy-Related Services: Services for the treatment of conditions or complications that exist or are exacerbated because of pregnancy. This includes, for example, -
   a. Medical services to treat a threatened miscarriage or premature delivery;
   b. Treatment of condition or complications that exist or are exacerbated because of pregnancy (such as diabetes, hypertension, epilepsy, preeclampsia, eclampsia, postpartum depression, choleliathis, cholecystectomy, etc.);
   c. Treatment of sexually transmitted diseases;
   d. Services required to treat an accident or illness that occurred before delivery;
   e. Medically necessary services to ensure a healthy maternal outcome and a healthy outcome for the current pregnancy and the unborn child. NMAP also covers associated services during pregnancy and around the time of delivery to ensure a healthy maternal outcome. This includes, but is not limited to services such as dilation and curettage to treat complications of pregnancy, such as miscarriage or retained placenta; tubal ligations, and gynecological surgery, such as gynecological tumor removal, etc.;
   f. Medical services to treat complications in the postpartum period; and
   g. Home health services for pregnancy-related services;

   Note: For risk reduction services for HEALTH CHECK participants, see 471 NAC 33-003.02.
2. Prenatal Services: Services to a woman during pregnancy which are directed to protecting and ensuring the health of the woman and the unborn child.
3. Delivery Services: Services necessary to protect the health and safety of the woman and unborn child from the onset of labor through delivery.
4. Postpartum Services: Services provided to a woman following termination of pregnancy for any health conditions or complications that are pregnancy-related. Note: Medicaid funding is not available for postpartum services related to induced abortions that are not covered by Medicaid.

5. Family Planning Services: See 471 NAC 1-002.01E, including tubal ligations.
6. Drugs: Those drug products prescribed during pregnancy (through the postpartum period) when necessary for treatment of existing and pre-existing conditions which affect the health of the mother or the unborn child. NMAP covers drug products prescribed during the postpartum period for new conditions directly related to the pregnancy, delivery, and family planning.

Written justification may be requested from the provider to substantiate medical necessity for these services.